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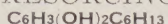
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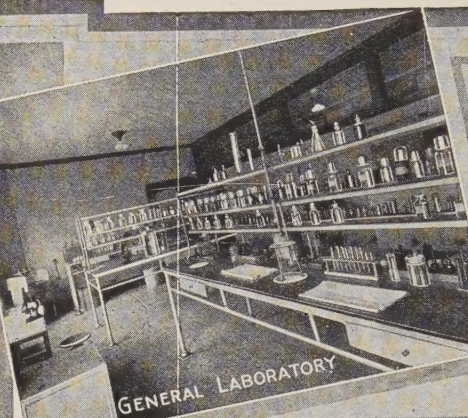
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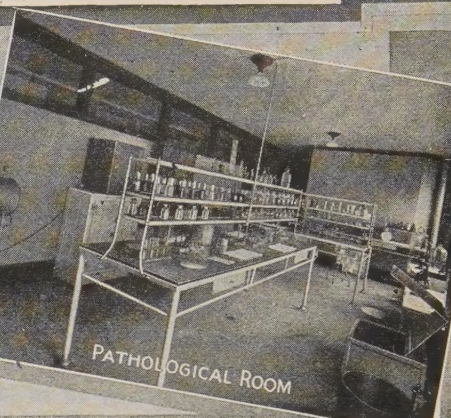
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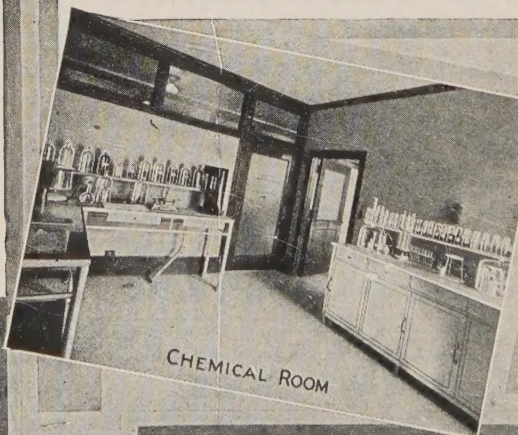
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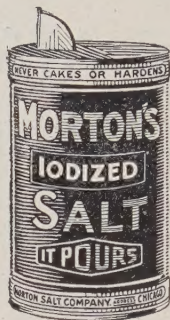
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ORIGINAL ARTICLES

Symposium on Goiter From the Viewpoint of the Pathologist*

LLOYD ARNOLD, Chicago, Illinois Department of Pathology, Loyola University
School of Medicine and Mercy Hospital

In considering the pathology of the thyroid gland there are certain standards that one must clearly define and use in the correct interpretation of pathological processes in this gland that are not applicable to other glands of the body.

The progressive centrifugal growth, from within outwards, of new vesicles is not found in any other gland. The peripheral portion of a lobule always contains the youngest vesicles. The frequency of metastized thyroid tissue from a structurally benign gland illustrate this independent power of growth. The great vascularity of the thyroid gland and its variations are too well known to be discussed at this time. The vesicle or functioning unit of the gland is a coiled tube within a lymph space. The apparent acini are sections of this tube at various angles or through different

planes. (Lantern slides to illustrate this point.) The remarkable hyperplastic response of the thyroid gland to functional stimuli is unique. Lymphoid tissue has a great power of adaptation, but even this tissue does not exhibit such profound and rapid morphological changes to stimuli as does the thyroid gland. These functional hyperplasias are characterized by a uniform enlargement of the gland. These changes in the size of gland are due to a physiological stimulus for an increase of the secretory product of the gland. The gland enlarges during puberty and pregnancy, an increase in size is also noticed during many infectious and metabolic diseases that are accompanied by some disturbances in the heat regulating mechanism of the body. Such hyperplasias can be induced by changes in diet; by certain drugs, etc. The specific secretory product of such hyperplastic

*Read before the American Association for the Study of Goiter at its annual clinical meeting, Bloomington, Illinois, January 29, 1925.

thyroid glands does not elevate the basal metabolic rate. The whole process can be looked upon as one of physiological or functional hyperplasia.

The retention, or possibly increased formation, of colloid, in such functional hyperplasias leads to colloid goiter. These could be interpreted as physiological remissions without corresponding morphological reductions in size. Cysts of varying sizes may form by fusion of adjoining spaces, liquefaction and hemorrhage are common. Such alterations as pigmentation, fatty degeneration, fibrosis and calcification are often encountered.

If we define an adenoma as an organoid tumor which reproduces the structure of the gland, then we must differentiate between an increase in the number of vesicles of the thyroid gland due to a functional hyperplasia and an increase due to an adenoma.

An encapsulated group of vesicles, growing as a nodule in the gland, appearing upon section as distinct opaque areas and microscopically characterized by small vesicles with narrow and irregular lumen, the component cells do not differ markedly from these found in the periphery of a functional hyperplastic thyroid. Such encapsulated masses may vary from pin head to fist in size. The larger they are the more often one observes retrogressive changes due to accidents that interfere with the blood supply and lead to autolysis or cyst formation, hemorrhage, pigmentation, fatty changes, amyloid degeneration, fibrosis, calcification, etc.

If one remembers the potential growing power of the thyroid gland, such encapsulated benign nontoxic adenomatoid areas just mentioned can hardly be classified as true adenomas in the usual meaning of this term when applied to other glands of the body. Such isolated areas of growing thyroid tissue could be

interpreted as compensatory hyperplasia or as excessive purposeful new tissue growths. Inasmuch as the majority of such thyroids show evidence of gross retrogressive changes, excessive colloid, cysts, fibrosis, etc., in various portions of the gland; these isolated areas of growing thyroid tissue can best be considered as the response to a functional stimulus. Their adenomatous gross and microscopic appearance is due to the peculiarities of the development, structure and function of the thyroid gland.

The general term adenoma is used by the clinician and pathologist in describing pathological growths in the thyroid gland. Adenomas, as previously defined, constitute a group of tumors that are met with daily by the pathologists and surgeons. Adenoma of the breast, adenoma of prostate, adenoma of the bile ducts, and many such adenomata are clear defined organoid tumors which reproduce the structure of the gland. But the term adenoma of the thyroid does not convey to me a picture so complete as the adenomas just mentioned. This is for the reason that we have used the same standards for comparison and have not taken into consideration the peculiar development, structure and function of the thyroid gland.

Degenerative changes in the thyroid gland are probably due to a great extent to an interference with the blood supply to that portion of the gland. If this occurs during or after adolescence, due to distention of certain lobules with colloid—pressing upon adjacent blood vessels,—then there will be more glandular tissue formed at some place in the gland to supply the needs of the organism; that is providing both the gland and the organism are normal. If these new vesicles are distributed over the periphery in a uniform manner, then we have a slight increase in the size of the

gland; if on the other hand, these new vesicles are formed in one place and grow as a small circumscribed tumor, then we have what is usually called an adenoma. I can hardly follow this line of reasoning. We have a functional hyperplasia in both instances. This encapsulated mass of new thyroid gland tissue is not an adenoma, and should not be considered as an adenoma in the usual accepted meaning of term.

True adenomas of the thyroid gland are found, but not nearly as often as the functional hyperplastic growths just mentioned. The cells are all smaller, being cuboidal in shape, the lumen is very narrow and does not contain stainable secretory products. All of the vesicles are of the same size and tightly packed together. There is always a rich blood supply to such encapsulated adenomas. Carcinomatous changes are encountered in such adenomas as are found in gland tumors in other organs of the body.

Van Noorden states that "the thyroid acts on oxidation as a pair of bellows rejuvenates a fire." The active substance liberated from thyroid gland has the specific action of increasing oxidation. When this is administered to a normal person the oxidation of the body is increased, hence the elevation of the basal metabolic rate. This seems to be brought about by an increase in the metabolism of resting cells. There is a delicate balance in the body between the secretion of the thyroid gland and the needs of the body for this product. Degenerative changes in the thyroid gland as a result of local circulatory disturbances decrease the thyroid tissue and diminish the supply of its secretory product. The gland cells increase in number at some place in the gland to compensate for this loss of secreting

tissue. This represents our functional hyperplasias just mentioned.

It has recently been shown that the injection of serum of an animal, that has been suddenly subjected to a low temperature environment, into a normal or thyroidectomized animal will increase the basal metabolic rate, but this is not true when the serum of a thyroidectomy animal is used under the same conditions.

It may be mentioned in this connection that in those areas where goiter disturbances are prevalent we notice the climate is characterized by sudden changes in temperature. In such environments we find infections of the upper respiratory tract and adjacent sinuses rather common occurrences. The author does not wish to ignore the present ideas of mineral content of drinking water as playing an important role in goiter districts, but wishes to add to these predisposing factors others that can play a role in the functional hyperplasias mentioned in this article. The demand of the body for thyroid secretion can be varied widely within physiological limits, and when as a result of a pathological retrogressive condition, still increased demand is put upon the gland for its secretion; then hyperplasias of various intensities will result. The reader is particularly interested in the problem of the influence of the thyroid upon the maintenance of the temperature equilibrium of the body, but time does not permit a further discussion of this problem.

In conclusion, I wish to emphasize the importance of certain peculiar features of the thyroid gland in its development, structure and function and call to your attention the necessity of taking these things into consideration in interpreting the pathological lesions of this gland.

A Goiter Survey in the Public Schools of Denver*

VIRGINIA C. VAN METER, M. D.

This work was inspired by Doctor David Marine and Doctor Haven Emerson. In May, 1924, at the request of Doctor A. L. Beagler, Director of Health Education in the Denver public schools, this goiter survey was made. The purpose was to determine the incidence of endemic goiter among the girls in the public schools in order to discover whether prevention of endemic goiter was a necessary problem.

The standards used were those set by Marine in his surveys in Ohio. (The Prevention of Simple Goiter in Man. Marine and Kimball. J. Lab. and Clin. Med. 1917, Vol. 3, 40-48.) Marine's classification was followed, that is, the glands were considered as normal, slight, moderate and marked enlargements, and adenomas. *The normal* included all glands 1, not visible as a bulging of the skin across the trachea, 2, having a barely detectable band of thyroid tissue across the trachea as elicited by palpation, and 3, those showing an absence of a well defined thyroglossal stalk. *Slight enlargements* were glands with a visible bulging of skin over the thyroid isthmus (except in very stout children) and those glands showing a widened thickened isthmal band or mass on palpation. *Moderate enlargements* were glands presenting a gross deformity, a bulging of the neck laterally from enlarged lobes and a marked bulging of the skin anteriorly from an enlarged isthmus. All glands showing excessive deformity were classed as *marked enlargements*. Glands with nodular masses were classified as adenomas.

The method of making the survey is

*Read before the American Association for the Study of Goiter at the annual meeting at Bloomington, Illinois, January 30, 1925.

as follows. All girls from the fifth to the twelfth grades inclusive were examined, the total number was about 10,000. The thyroid examinations were all made by the same person thereby insuring a uniformity of the work. The same school nurse made all the notations which insured uniformity of data. Printed record cards were distributed to the schools and filled out before the doctor and school nurse arrived. On arriving at a school it was a simple matter to examine each pupil. A steady stream of pupils, each with her own card in her hand, walked in single file to the nurse and handed her the card. Each girl was then examined by the doctor who dictated in code the notation which the nurse made upon each card. The word "goiter" was never mentioned either before the pupils or to the teachers. The record cards were labelled "thyroid examination" and no one was alarmed by the term "goiter survey."

RESULTS

2,643 thyroid enlargements were found in 9,656 girls between the ages of 8 and 22. The percentage of enlargement was 27.3. Of the 2,643 enlargements 2,443 were slight, 197 were moderate and 3 were large goiters. The percentage of enlargement in the 17 year old white girls was 45.0.

Colored people enjoy no racial immunity to endemic goiter. The percentage of enlargement for 163 colored girls was 26.3, for the white girls it was 27.3.

Of the 9,656 girls examined only 9 showed adenomas or 0.09 percent.

SUMMARY

1. The incidence of endemic goiter in 9,656 girls in the fifth to the twelfth

grades inclusive is 2,643 or 27.3 per cent.

2. There is a necessity for the prevention of endemic goiter in Denver.

3. No racial immunity to endemic goiter exists among colored girls.

4. The use of iodized salt as a prophylactic measure is urged in the public schools of Denver.

5. The treatment of existing thyroid enlargements is left to the family physician.

6. The necessity for goiter preventive treatment for women during the first half of pregnancy should be given widespread publicity.

I wish to express my appreciation of the faithful and sympathetic assistance rendered by the school nurse, Miss Marie Merhaut.

I also wish to thank Doctor Robert Olesen for assembling the figures and percentages.

Is Ligation a Necessary Surgical Procedure?

M. O. SHIVERS, B.S., PH.G., M.D., Colorado Springs, Colorado

A thorough knowledge of the anatomical and physiological phases of the thyroid gland should concern the physician or surgeon who would best serve his patient suffering from thyroid disease.

Ligation was popularized by Wolfer. The operation was first performed back in the 19th century—the exact date could not be ascertained. Ligation has been practiced in this country for thirty-five or more years.

It has been my impression for some years that ligation was unnecessary and should be abandoned as a surgical procedure in the treatment of goiter. No ligation has been done by us since 1906. A mortality of less than 1% has justified our plan of treatment and very few patients have been denied the advantage of ultimate operation.

Ligation has its merits and has served its purpose well, but in the light of modern knowledge the procedure must be supplanted by safer methods. Any procedure that carries a positive and certain mortality in the treatment of any disease, when other measures can be instituted carrying no mortality and obtaining the same results, should be discarded. All results from ligation

can be obtained by the use of other measures that carry no mortality.

In reviewing the statistics from the various clinics covering a period of twenty years the figures seem to indicate a death rate of from 6/10 or of 1% to 2%, ratio decreasing from 1905 to date.

Some patients consider themselves completely recovered, following ligation, and allow relapses that prove fatal and these fatalities cannot be included in our statistics on ligation, even though they justly belong there.

C. H. Mayo's terse statement that the great lowering of mortality following operation for exophthalmic goiter is due less to trivial details of technique than to better judgment in preparation of patients, the selection of time, type and extent of operation and its division into stages with varying intervals of rest, is more pertinent today than ever before.

In 1915 Mayo Clinic states: "In at least one-fourth of the cases the condition is so extreme from the continued toxic condition or from acute exacerbation that the ligation of the vessel as advocated by Wolfer is advisable at least as a preliminary procedure. There is a relief from all symptoms and an in-

crease in weight and should thyroidectomy be undertaken it will be done with much less risk than the former procedure of ligation. Some patients are in such an extremity that preliminary treatment by heart tonics, diuretics, x-ray applications and absolute rest is necessary before even the resort to ligation of the vessels is advisable." Later reports from Mayo Clinic seem to indicate that very few ligations have been done in 1924. If the extreme cases can be, by medical treatment, brought up to a point of safety for ligation, further treatment will make them safe for thyroidectomy, thus avoiding the mortality that ligation definitely and certainly carries.

Exigencies that contra-indicate ligation also should interdict partial excision of the gland. No patient who fails to show signs of improvement after a well carried out plan of pre-operative treatment will recover from either ligation or partial excision of the gland.

Permanent cure cannot be expected from ligation, however Judd and Pemberton consider two types for operation—one in which the disease is mild and a cure might be expected—the other type in which the disease is severe and the ligation is preliminary to resection. Consensus of opinion is that virtually all ligated cases should have a resection as all cases without thyroidectomy suffer from subsequent attacks of hyperthyroidism.

One ligation is frequently followed by a recurrence or relapse and requires a second ligation with its attending danger or risk. Ligation in skilled hands is far safer than in the hands of the occasional operator. Only a casual observation of the last mentioned operator will show a mortality above one's expectation. In fact, in the hands of the occasional operator, I would prefer my chances with resection of the diseased gland, as the

field of operation is well exposed and less damage is likely to be done.

Patients selected for ligation are in a serious condition and some develop most alarming symptoms following operation, due to absorption of excessive secretion in the gland and to toxins in the circulatory system, thus producing a thyro-toxic death.

What pre-operative plan will take the place of ligation? Rest, medical treatment (iodine, bromides, quinine hydrobromide, ergotine, digitalis), ice to the gland, boiling water injections, addition of fluids, x-ray.

Rest in bed, not continuously, over a long period. Better an up and down plan after the first few days of absolute quiet. Fear and anxiety that naturally go with hospitalization tend to make some patients worse and should be avoided. Home treatment goes well with this class of patients in the pre-operative plan as followed by us. Application of cold to the gland at intervals during the rest period has a marked beneficial effect. Addition of fluids and increase of caloric intake are most valuable adjuncts. X-ray certainly renders toxic cases operable and will diminish the risk of operation but has very little place in permanent cure.

In the very ill a small percentage do not yield as promptly as they should to medical treatment. Boiling water continuously and carefully injected into the gland and repeated as necessary will produce satisfactory results and without danger to the patient. This treatment should be given at the bedside under gas anesthesia, only three to four minutes being necessary to complete the treatment, a time too short for ligation.

Quinine hydro-bromide not only acts in a favorable manner on the heart itself but may have an additional antiseptic effect in the event an infective agent is the causative factor in the production of

goiter. Ergotine acts directly on the blood supply, thus lessening absorption of toxins. The suggestion that iodine reduced thyroid activity and caused a marked improvement of symptoms in exophthalmic goiter and its administration has brought many more cases into the operative column and has reduced the operative mortality by lessening hyperthyroidism. Following Plummer's suggestion iodine is being popularized as a pre-operative drug in the preliminary treatment of goiter with results that seem almost unattainable.

Iodine may stir up an inactive adenomatous gland, consequently carries a potential danger that is sometimes overlooked. We have not and do not give iodine compounds to goiterous patients as we believe bromides are more satisfactory.

The Halligen group is made up of chlorine, iodine, bromine and fluorine, consequently iodine and bromine belong to the same family. Both possess in common a highly antiseptic and germicidal effect. We think of bromine and bromides only from a sedative standpoint and not as having a direct effect on the thyroid gland itself. Chemically bromides do act favorable on the gland, producing positive beneficial results and causing no unpleasant effects and can be administered almost indefinitely with no harmful results. The thyroid individual tolerates bromide not unlike the leuitic does iodine.

We are convinced that the action of bromide is not so rapid as iodine but is just as certain and has the additional advantage of being sedative in action. Ease of administration per rectum—Murphy method—commends its use to the vomiting patient and in the diarrheal cases the addition of tincture of opium makes it possible to be given when oral

administration of iodine is out of the question.

In the administration of either iodine or bromine one should remember that chlorine interferes with the action of bromine but augments the effect of iodine. This fact must be taken into consideration particularly when bromide is being given by the rectal route, as all are prone to give saline solutions in conjunction with other solutions given by this method.

Pre-operative treatment other than ligation stands out pre-eminently in the acutely ill. Such a picture is indicated by high metabolic rate, rapid and weak pulse, extreme nervousness, loss of weight, weakness, vomiting and diarrhea, cardiac dilatation and other evidences of visceral changes.

Disadvantages of ligation may be summed up as follows:

1. Produced dangerous reactions as prostration and fever.
2. A definite number of cases ligated one or more times do not improve sufficiently to warrant radical operation.
3. Late operations following ligation are more dangerous and difficult.
4. Alarming symptoms of thyrotoxicosis.
5. Physiological—By disturbing the circulation without giving an outlet for the toxins, thus throwing additional burdens on the economy.

The final treatment of thyroid disease is partial excision of the gland. Recurrences are far too frequent from all other methods to give consideration to them only as preparatory. We must not mistake an arrest for a cure. Herein lies the great danger of medical treatment. Ligation seems to be an unnecessary procedure and the time is not far distant when the operation will be obsolete, improper and unwise.

Pre-Operative and Post-Operative Management of Adenoma with Hyperthyroidism

FROST C. BUCHTEL, M. D., Denver, Colorado

Assistant Professor of Surgery, Medical School, University of Colorado

The goiter prevention campaign has taken such a strong hold on Denver that now when one orders salt from his grocer he is asked whether he wants iodized salt or plain salt. This is a true statement of fact; not a fabricated sentence to elicit your commendation. It means that in Denver sufficient publicity has been given to the value of iodine as a necessary component of food so that now it is common knowledge possessed by a certain portion of our community.

The educational program on goiter, however, has only begun. The veterinary surgeon has served his constituency more efficiently in this respect than the doctor of medicine. The pregnant sow is rather more apt to receive appropriate iodine therapy than the pregnant wife.

If adolescent goiter is an iodine-deficiency disease and if adenoma of the thyroid is in some way closely connected etiologically with the development of adolescent goiter, the incidence of adenoma should be very materially minimized by the appropriate administration of iodine at certain periods of the individual's life, especially during the early foetal months through the mother's blood, and again during the second decade.

The students who have graduated from the University of Colorado School of Medicine in recent years are as familiar with the work of Marine and Col. McCarrison as they are with the etiology of thyroid fever. We can rely implicitly on the enthusiasm and zeal of the youth in our profession to carry on the educational program of prophylaxis of goiter.

However, as a majority of the patients in our various communities will continue to be handled by the older men in the profession it will be many years before the class room instruction of today becomes the general consensus of professional opinion. Our ideas of goiter are changing so rapidly and these ideas are so practical and important that a definite organized effort, as exemplified most conspicuously by this society, to reach the ear of every practicing physician is most praiseworthy.

The general situation of goiter is, nevertheless, encouraging. All over the country patients with exophthalmic goiter are coming for treatment earlier, before the advent of a marked heart degeneration. Of course the physical signs of exophthalmic goiter are so obvious that the patient or the patient's friends often make a diagnosis before any physician is consulted. The symptoms and physical signs of adenoma with hyperthyroidism are not of such a character that the diagnosis will ever be made by laymen. The latent danger of thyroid enlargement, however, can be stressed so that patients will consult physicians many years before the onset of hyperthyroidism.

In the New Year's edition of the Saturday Evening Post, Woods Hutchinson has a long article on goiter prevention. The article would be just as entertaining and more instructive to the layman if it were scientifically accurate. A wonderful opportunity was overlooked to give some real information about the late dangers of neglected thyroid enlarge-

ment. The real problem is to get the physician to cooperate in bringing these patients to early operation. While the task is great it is not insuperable. Every state society program should be considered incomplete without at least one paper or symposium on the subject of goiter, and the same may be said of constituent society meetings. This intensive educational program should be continued until the general practitioner knows as much about goiter as he does about the other diseases he sees. Many a fairly well-informed physician who easily and quickly recognizes the danger and significance of pain in the eye with an increased tension in the eye ball, or who immediately asks for a specimen of sputum on finding a few rales at an apex of one lung in a patient who has come for examination on account of a cough, or who requests surgical counsel on finding a patient who has vomited and who has abdominal pain and slight tenderness, and rigidity in the right flank, will treat a cardio-vascular patient for months without any examination of the thyroid gland. If in his examination an asymmetrical thyroid enlargement is observed and mentioned, the statement of the patient that the growth has been there for twenty years and has never bothered him is in many instances a sufficient reason for not regarding the thyroid as etiologic of the patient's general condition.

For at least a generation to come the incidence of adenoma with hyperthyroidism will be high. As the development of hyperthyroidism in these cases is slow and insidious the patients are apt to come under observation late in their disease, after the development of marked degeneration of vital organs. Unfortunately, the actual cause is not always recognized by the attending physician as quickly as it might be, so that many of the patients are bad surgical risks by

the time they finally come under the professional care of the man who does goiter surgery.

One of the many very valuable contributions to medical literature that has come from the Mayo Clinic was Doctor Plummer's discovery two years ago that large doses of Lugol's solution act as a specific in the preoperative treatment of exophthalmic goiter. This fact has been so emphasized that the idea is now rather prevalent that there is no effective preoperative treatment of the hyperthyroidism occurring in cases of adenoma. The diseases for which we have definite specific drugs are relatively very few as compared with the large number of affections we are compelled to treat more or less symptomatically and yet our results justify our efforts in this latter group.

The preoperative treatment of adenoma with hyperthyroidism is wholly symptomatic. It enables one, however, to improve temporarily the general condition of the patient so that when he is taken to the operating room he is in better condition to stand the strain of operation than at the time of his admission to the hospital. The most painstaking care and attention are necessary to accomplish this end.

The problem is always an individual one. Special indications for treatment vary in different cases.

The cardio-vascular class is the largest. The various manifestations of myocarditis, however, would require hours to describe. Most of the patients have arrhythmia caused by premature systoles, auricular fibrillation or auricular flutter. Some of the patients have decompensated hearts with oedema, ascites and liver enlargement.

The arterial conditions in individual cases vary as much as the hearts and the kidneys.

The degree of muscular weakness also varies in different patients.

In some of the patients the nervous system seems to bear the brunt of the disease.

Any one of the above enumerated pathological conditions may call most urgently for treatment, or there may be such a combination of symptoms as to tax one's therapeutic ingenuity.

The psychic aspect of the case should always be kept prominently in mind in dealing with hyperthyroid cases; therefore, I believe it best for the operator to retain the active preoperative care of the patient, insuring competent management of the case by frequent consultations with a heart specialist. If the patient likes a good deal of attention, the medical adviser also should see the patient on his daily rounds at the hospital. The orders should come from the operator, however, as this will increase the patient's confidence in him.

The one thing that all patients need is rest: physical and mental. The selection of a quiet room is valuable and the choice of proper special nurses is of great importance. The patient's idiosyncrasies should be studied and properly met. If he happens to be very devout, spiritual guidance should be provided.

Patients with heart decompensation should receive massage, the duration and frequency being determined by the results. Some of the nervous patients are also quieted and benefited by massage.

Some of the patients require venesection, puncture of the legs for oedema and tapping for ascites.

The drugs will, of course, vary according to indications. Digitalis, quinidine and morphine are the ones most frequently employed. Some time before the operation a trial dose of hyoscin is desirable to determine the patient's reaction to and tolerance of this drug. Luminal and bromides are indicated oc-

asionally. "Nature's sweet restorer"—sleep—is a wonderful help if it can be induced. Some patients are apparently helped by Lugol's solution. Most of the patients benefited by iodine therapy have finally shown, on pathologic examination of the thyroid, a hyperplasia in addition to the adenoma. This is suggestive that the hyperthyroidism was due to an atypical exophthalmic goiter and the adenoma merely a coincidental lesion.

The diet and fluid intake require thought. A far advanced myocardial case can not be fed as an exophthalmic patient would be fed. The functional capacity of the kidneys must be studied and borne in mind in ordering the diet and the amount of water.

Some patients are helped by having focal infections in the mouth attended to before their operations. This can be done by the dentist while the patient is in bed at the hospital.

I believe that practically no patient who can be moved to the hospital in an ambulance should be rejected for treatment until after a very definite and honest effort has been made to see what response he will make to some such treatment as that outlined above.

Some patients do not require a week's rest before operation; most of them can be benefited materially in two or three weeks, but occasionally a longer period is required.

The immediate preoperative medication I regard as important. Luminal is given the night before operation. One and one-half hours before operation a suppository of ten or fifteen grains of chloretone is given. At the same time a hypodermatic injection of morphine, gr. 1/6, and hyoscine gr. 1/200 is given. An hour before operation another dose of morphine, gr. 1/6 or 1/8 is given with atropine gr. 1/100. The hypodermatic injections are given in 2 c. c. of

chemically pure 25% magnesium sulphate solution.

As a result of cautious trials the patient's reaction to and tolerance of these drugs is known and the dosage regulated accordingly. In some cases three hypodermatic injections are given, each containing a sixth grain of morphine. I give as much morphine just before the operation as I have found the patient can tolerate.

I formerly did most of my goiter operations with local anesthesia. I now use gas and oxygen as a routine and reserve local novocain anesthesia for the very desperate risks.

As a general rule the same drugs are used post-operatively as were found to be most helpful before operation. A gradual withdrawal of drug therapy is possible as the hyperthyroidism decreases.

Elastic compression by a surgical dressing has been used for centuries. A clean and practicable method of obtaining good elastic compression is by the use of rubber bath-sponges. Such use of rubber sponges has been employed for several years in the Wolff skin-graft. At the last meeting of our Colorado State Medical Society, Doctor Leonard Freeman suggested their use in general surgery. Since that time I have been using a large red rubber bath-sponge over the sterile dressings on each side of the neck. The amount of drainage is thereby greatly lessened; dead spaces are obliterated, thus minimizing the danger of infection, and healing by first intention without any annoying sinus is promoted. The idea is sound theoretically. It takes no additional time to use the sponges, the patients are more comfortable with the elastic compression and the results are all that is claimed for the method.

Although the hyperthyroidism disappears in three weeks or less after opera-

tion, many of these patients require watchful care for a long time to restore them to lives of usefulness. While drugs are indicated for a time they should soon be supplanted, in most cases, by other methods of management. Proper habits, right mode of living, appropriate exercise, the Oertel treatment or the Schott movements for the heart and sufficient rest will give the best results.

The ultimate outcome will depend on the amount of residual pathology, but it should be remembered that the degree of recovery is usually greater than one would imagine possible from the functional disability present at the time of one's first examination.

Attention is directed to the value of the following points:

1. The general use of iodine to lessen the incidence of adenomatous goiter.
2. Surgical removal of adenomatous goiter before the advent of hyperthyroidism.
3. Rest, certain general management and symptomatic drug therapy as a pre-operative treatment in cases of adenoma with hyperthyroidism.
4. Synergistic anesthesia.
5. Sponge compression after operation as obtained with the ordinary red rubber bath-sponge.
6. Long continued supervision after dismissal from the hospital.

CYSTINURIC LITHIASIS

Cystinuria is an error of metabolism which is inborn and incurable. The case of cystinuria reported by S. J. Seeger and W. M. Kearns, Milwaukee (*Journal A. M. A.*, July 4, 1925), was complicated with calculi. The calculi were multiple and mixed with other salts. After operative removal of the stones, the cystinuria persisted in this case, even in a urine alkaline to litmus, emphasizing the necessity of the microscopic test to determine the absence of cystin in the urine. No other members of the family have been found to be affected by cystinuria, although the father and a brother had microscopic blood in the urinary sediment on two occasions.

Dr. Robert H. Babcock

A dinner was given Doctor Robert H. Babcock by his many medical friends and admirers on the evening of November tenth at the Drake Hotel. The dinner was not given to celebrate a birthday or some such event, but to honor a man who has attained great medical eminence.

Doctor Babcock is too well known in the medical profession to need an introduction. His reputation as a diagnostician and as an internist of outstanding place, makes his name familiar to students of medicine. His works and his writings upon diseases of the heart are also well known to all medical men.

It seemed a proper time to extend the courtesy of a dinner to our friend of long acquaintance that he might realize the high respect in which he is held by his friends and contemporaries.

Dr. James B. Herrick presided at the speaker's table in his delightful humorous vein. Mr. Edward Sweet, an old friend from Grand Rapids, sat at Dr. Babcock's right. Besides, Drs. Frank Billings, William Pusey, Hugh Patrick, William A. Evans and Rev. John Timothy Stone, were at the table. There has rarely been a finer display of wit than at this dinner.

Dr. Babcock responded to the sallies of his friends with his usual brilliancy. The serious touch was revealed, only, when in answer to Dr. Patrick's remarks, Dr. Babcock spoke of the two women who had sustained him through his great affliction by constantly keeping him up to the best in him—his mother and his wife!

Let us give more dinners, dinners that bring encouragement, and not wait until the friend has retired from active work.

DR. ROBERT H. BABCOCK*

BY ARTHUR M. CORWIN, M. D.

November by a custom old
Strolls past in garb of brown and gold
And on each leaf by zephyrs tossed
Has left her finger print of frost.

The season is a time for feast
And song, for thanks and smiles, at least
It is most a *propos* to dine,
Though Volstead has denied us wine
When grapes most tantalize, that is,
They have great possibilities.

So, though the flowing bowl we lack
And merely reminis of sack,
Or get by stealth a lawless sip
Of boot-leg liquor off the hip,
We gather at this sober board
With joyous souls, by one accord
We lift and drink, as drink we can,
Of chlorine tinctured Michigan.

But while aseptic healths we quaff
And court longevity to laugh
We shall not for a moment think
That life is chiefly eat and drink,
That satisfaction at its best
Is but an optimistic jest.

If pleasure is the stake we win
From this brief race we're running in,
'Twere well, for happiness is but the goal
Attained by each inspired soul
Devoted to the good, the true,
The beautiful, that only I and you
Achieve by sacrificing low
To motives high; and so we grow
In character and strength of mind
And are most happy when most kind.

And so good fellows, we immerse
Ourselves in philosophic verse
And drink to Robert Babcock, great,
Whose high accomplishments relate
To high resolves, to noble toil,
To cultivated taste which naught could spoil,
No handicap defeat, for he
Was kindled from within to see.

*Read at a banquet given to Dr. Babcock at the Drake Hotel, Nov. 10, 1925.

Oh! mortals, with immortal ties
 That link eternal verities,
 Superlatively good to know
 Behind the cloud the sun doth glow,
 Superlatively good to find
 The friendship of this noble mind.

THE BABCOCK I KNOW

DR. HUGH T. PATRICK

Naturally there are many Babcocks. First, there is the Babcock he thinks he is, and of course no living man knows what he thinks. Equally, of course, modesty forbids that he should say what he thinks. Then there is the Babcock that, for example, Paddock sees. Third, there is the Babcock that Babcock thinks Paddock sees. Fourth, there is the Babcock that Paddock thinks Babcock thinks Paddock sees. And so on *ad infinitum* for each of us. Hence to make you see the Babcock I know evidently is impossible, but I should like to start by saying that if I were suddenly given the powers of the Creator and ordered to build a good man, I should begin by taking a great chunk of courage, molding it in kindly lines and work on from that. And if I were ordered to build a good doctor, I should begin in exactly the same way. All the rest of my great doctor or fine man would simply be added qualities for utility and embellishment: traits that make our friends lovable, useful and interesting, even popular and to be admired. But no man and no doctor can be great or good whose foundation is not courage. And to me the outstanding feature of Babcock and his career is his courage. His history is an epic in courage. Early burdened by an enormous handicap he simply would not be downed. Later, when this handicap was increased, he continued to live as others and do the things others did. He not only graduated in medicine but after graduation went to another university where the requirements were

supposed to be higher and graduated there. He not only succeeded in practice but has been vastly more successful than most of us. He not only wrote a book, (and I must confess I stand in awe of any man who can bring a book to completion) he wrote two books, big books, and, what is more, both of them good. He became a successful professor and teacher, and he won for himself a wonderful wife. In short, by his monumental courage, by his spirit of *never* say die he annihilated the disability an unkind Fate had dealt to him and became even as others,—only greater. He shaved himself before the birth of the safety razor. I have played bridge with him, and he played a good game. He toured Switzerland on a tandem bicycle and will describe to you the beauties of the Alps and the quaintness of the villages. Years ago at a dinner one of the guests expressed admiration of an odd and beautiful Etruscan vase in the room. The host took it down and told us about it, when Babcock said "let me *see* that." It was passed to him and he did see it—with his palpating fingers. He carries a watch even as you and I and tells the time as quickly. Accidentally I overheard his assistant reading to him a medical article and the speed with which he went through it was amazing. The reader would get about one-fourth through a paragraph when Babcock would say "skip that." And again in a moment "skip that." And presently "read that again." In short he skimmed the cream from that paper as quickly as I could do it. Once, on a lovely day in May, he and I traveled by train to Peoria. At some station we were bumped about more or less, to which I paid no attention as we were busy talking. After we were under way again Babcock remarked "They cut out a car there." "How do you know," I said. "Why, we are a car's length nearer the engine." He

was right. A little while later, Babcock sitting next the window and I on the aisle, he was facing straight forward and I was looking past him at a lovely sunset, when he casually remarked, "It's a beautiful sunset, isn't it?" It was startling, I assure you. "How in the world do you know, Babcock?" I asked. "Oh, I feel the warmth of the sun on my cheek." Arrived at our hotel, we were shown to a big room with two beds. Babcock made one excursion of exploration and thereafter was as much at home in that room as I was. Maybe some of you don't know that Babcock is a poet. At least he is a versifier of parts. And I here and now dub him limerick laureate to the medical profession. That's the kind of a chap he is.

Most of us are deeply touched by a tender poem or a sympathetic picture. We are strangely moved by the grandeur of mountains, the majestic vault of heaven at night or by the weird immensity of the grand canyon of the Colorado. The music of a great orchestra or a powerful chorus may send strange

sensations chasing up and down our spine. But there is something in indomitable, fearless, deathless courage that fairly clutches us by the heart and carries us away. This is the courage of Babcock and with it he has led me captive. When to this splendid courage we add brains and kindness, helpfulness and modesty; loyalty to duty and to friend, you know the Babcock I know, and with me I know you will take off your hat to him.

Now, Babcock and friends, I can not sit down without just a word for the woman who loved my friend early and loved him long; the woman who married him an untried, handicapped, embryonic doctor; the woman who believed in him, encouraged him; ever by his side, aided him with hand and brain and eyes; who made him to see lovely women and stalwart men, the grandeur of a landscape and the beautiful setting of a dining table. Who can plumb the depths of a woman's love? Certainly never a mere man. We can only wonder and worship. And that we do.

Custer's Last Battle

By One of His Troop Commanders

(Reprinted from the "Century Magazine" of January, 1892.)

Continued from November Issue.

COMMENTS BY GENERAL FRY ON THE CUSTER BATTLE.

Captain Godfrey's article is a valuable contribution to the authentic history of the campaign which culminated in "Custer's Last Battle," June 25, 1876.

The Sioux war of 1876 originated in a request by the Indian Bureau that certain wild and recalcitrant bands of Indians should be compelled to settle down upon their reservations under control of the Indian agent. Sitting Bull, on the Little Missouri in Dakota, and Crazy Horse, on Powder River, Wyom-

ing, were practically the leaders of the hostile Indians who roamed over what General Sheridan called "an almost totally unknown region, comprising an area of almost 90,000 square miles." The hostile camps contained eight or ten separate bands, each having a chief of its own.

Authority was exercised by a council of chiefs. No chief was endowed with supreme authority, but Sitting Bull was accepted as the leader of all his bands. From 500 to 800 warriors was the most the military authorities thought the Hos-

tiles could muster. Sitting Bull's camp, as Custer found it, contained some 8,000 or 10,000 men, women and children, and about 2,500 warriors, including boys, who were armed with bows and arrows. The men had good firearms, many of them Winchester rifles, with a large supply of ammunition.

War upon this savage force was authorized by the War Department, and was conducted under the direction of Lieutenant-General Sheridan in Chicago.

The campaign opened in the winter, General Sheridan thinking that was the season in which the Indians could be "caught." He directed General Terry to send a mounted column under Custer against Sitting Bull, and General Crook to move against Crazy Horse. Bad weather prevented Custer's movement, but Crook advanced March 1. On March 17, he struck Crazy Horse's band, was partially defeated, and the weather being very severe, returned to his base. The repulse of Crook's column, and the inability of Custer to move, gave the Indians confidence, and warriors by the hundred slipped away from the agencies and joined the Hostiles.

In the Spring Sheridan's forces resumed the offensive in three isolated columns. The first column, under Crook, consisting of 15 companies of cavalry and 5 companies of infantry (total 1,040), marched northward from Fort Fetterman May 29. The second column, under General Terry, consisting of the entire 7th Cavalry, 12 companies (about 600 men), 6 companies of infantry, 3 of them on the supply steamboat (400 men), a battery of Gatling guns manned by infantrymen, and 40 Indian scouts, moved westward from Fort A. Lincoln, on the Missouri, May 17.

It happened that while the expedition was fitted out, Custer unwittingly in-

curred the displeasure of President Grant, who directed that Custer should not accompany the column. Through his appeal to the President and the intercession of Terry and Sheridan, Custer was permitted to go in command of his regiment, but Terry was required to accompany and command the column. Terry was one of the best of men and ablest of soldiers, but had no experience in Indian warfare.

A third column under General Gibbon (Colonel of Infantry), consisting of four companies of infantry (450 men all told), marched eastward in April, and united with Terry on the Yellowstone, June 21. When these columns started they were all some 200 or 300 miles from the central position occupied by the enemy. Gibbon was under Terry's control, but Crook and Terry were independent of each other.

The authorities believed that either one of the three columns could defeat the enemy if it "caught" him; otherwise isolated forces would not have been sent to "operate blindly," without means of mutual support, against an enemy in the interior of an almost totally unknown region. Indeed, General Sherman said in his official report of 1876, "Up to the moment of Custer's defeat there was nothing, official or private, to justify an officer to expect that any detachment would encounter more than 500 or 800 warriors." The appearance of 2,500 to 3,000 in the Custer fight, General Sherman adds, "amounted to a demonstration that the troops were dealing, not only with the hostiles estimated at from 500 to 800, but with the available part of the Agency Indians, who had gone out to help their friends in a fight."

The utter failure of our campaign was due to under-estimating the numbers and prowess of the enemy. The strength he was found to possess proved, as General

Sherman said in his report, "that the campaign had been planned on wrong premises." Upon this point, Gibbon said, "When these various bands succeeded in finding a leader who possessed tact, courage, and ability to concentrate and keep together so large a force, it was only a question of time when one or the other of the exterior columns would meet with a check from the overwhelming numbers of the interior body."

The first recall was that Crook's column encountered the enemy, June 17, and was so badly defeated that it was practically out of the campaign.

In his official report, Sheridan claims for Crook "a barren victory," but adds, "Next day he returned to his supply camp on Goose Creek and awaited reinforcements and supplies, considering himself too weak to make any movement until additional troops reached him."

On the 21st of June, Terry, with the column from the east, about 1,000 men, was on the south bank of the Yellowstone, at the mouth of the Rosebud. Gibbon was with Terry, and his column from the west, 450 men, was some fifteen miles up the Yellowstone on its north bank, nearly opposite the mouth of the Big Horn. The Rosebud and Big Horn flow from south to north about fifteen miles apart, with a high, broken "divide" or ridge between them.

A scouting party had found indications that the Indians were on the Big Horn or its tributaries, and they were found on the 25th about ninety miles away in the valley of the Little Big Horn, with some 2,500 warriors. At that time, Terry did not imagine them to be so strong, nor did he know that Crook had been defeated on the 17th. He heard nothing of Crook until July 4.

On the night of June 21, Terry held a conference with Gibbon and Custer, at

which he says in his annual report in 1876, he decided upon a plan of operation, by which Gibbon was to move south up the Big Horn valley, Custer was to proceed up the Rosebud and ascertain the direction of the Indian trail, and

if it led to the Little Big Horn it should not be followed, but that Custer should keep still further to the south before turning to the river, in order to intercept the Indians should they attempt to pass around his left, and in order, by a longer march, to give time for Gibbon's column to come up. . . . This plan was founded on the belief that the two columns might be brought into cooperating distance of each other, so either of them which should be first engaged might, by a "waiting fight," give time for the other to come up.

Custer's disaster has been directly or by implication attributed to a departure from the "plan." No record of the conference appears to have been made at the time, but Terry's statement concerning it is supported by Gibbon, and no one would dispute it if it stood alone. But it is highly probable that the plan when Custer moved had neither the force nor importance which it subsequently acquired in Terry's mind. Terry made to Sheridan a full and explicit report, June 27, when the subject was fresh, in which he spoke of the conference, but did not say or intimate that a plan of operations had been decided upon in it. He did say, however, "I informed General Custer I would take the supply steamer up the Yellowstone to ferry General Gibbon's column over the river, that I should personally accompany that column, and that it would in all probability reach the mouth of the Big Horn on the 26th instant." If at that time Terry thought the plan of operations mandatory, he probably would have mentioned it in this report of June 27. It was, however, not until July 2 that he reported the existence of a plan; Then he

said in his report to Sheridan made in his own defense, "*I think I owe it to myself to put you more fully in possession of the facts of the late operations,*" and followed with the account of the plan, above quoted from his annual report, but did not say that he had issued any orders which Custer had disobeyed.

The plan decided upon in conference on the night of June 21 fixes no blame on Custer. His written instructions from Terry were made June 22, the day after the conference, and they were binding upon him. They made no reference to a plan, but said:

The Brigadier-General Commanding directs that, as soon as your regiment can be made ready for the march, you will proceed up the Rosebud in pursuit of the Indians whose trail was discovered by Major Reno a few days since. *It is, of course, impossible to give you any definite instructions in regard to this movement,* and were it not possible to do so the department commander places too much confidence in your zeal, energy and ability to wish to impose upon you precise orders which might hamper your action when nearly in contact with the enemy. He will, however, indicate to you his own views of what your action should be, and he desires that you should conform to them, unless you shall see sufficient reason for departing from them.

The order Custer received was to proceed up the Rosebud in pursuit of the Indians. Surely he did not disobey that. Everything else was left to his discretion. As Terry did not wish to hamper Custer's action when nearly in contact with the enemy, and found it impossible to give him precise orders, plainly Custer did not, could not, disobey orders in any blamable sense, and plainly, also, he was expected to come "in contact with the enemy."

Captain Godfrey says that the scouts were sent out on the right flank during the 23d and 24th moving along the divide between Rosebud and Tulloch's Fork, from which the valley of the Fork was in view. It is true Custer does not appear to have examined the upper part

of Tulloch's Creek, but there were no Indians there, and the omission, if it occurred, is colorless. He was directed to send a scout through to General Gibbon's column with the result of his examination of Tulloch's Creek, and was informed that Gibbon would examine the lower part of the creek. Whether he endeavored to send a messenger cannot be ascertained (Captain Godfrey says that a scout named Herendeen had been selected for this service, and he is of the opinion that General Custer would have sent him during the day if the fight had been delayed until early next morning, as he at first intended); but nothing concerning Tulloch's Creek was material in the campaign.

Even conformity to Terry's "views" was expressly left to Custer's discretion.

In his sermon at General Terry's funeral, December 29, 1890, the Rev. Dr. T. T. Munder said:

Custer's fatal movement was in direct violation of both verbal and written orders. When his rashness and disobedience ended in the total destruction of his command, General Terry withheld the fact of the disobeyed orders and suffered an imputation hurtful to his military reputation to rest upon himself, rather than subject a brave but indiscreet subordinate to a charge of disobedience.

When called to account for the accusation which he made against one dead soldier at the Christian burial of another, Dr. Munger gave Colonel R. P. Hughes of the army, a brother-in-law of General Terry and for a long time his aide-de-camp, as authority for his defamatory assertion.

Colonel Hughes denies having authorized Dr. Munger to make the statement, though he admits he was the source of Dr. Munger's information. Called upon more than once, he fails to produce or specify any orders disobeyed by Custer. Indeed, there can be no such orders. It is not credible that Terry issued orders which have never been produced by him

or any one else, and that these phantom orders if obeyed would have prevented the Custer massacre. Terry was a strict and careful soldier. It was his duty to file with higher authority all the orders he issued in the case, and his orders have passed in due course to their places in the public records, and have been discussed above. Custer disobeyed none of them.

Returning to the conference plan of operations, it must be noted that, like the general plan of campaign, it was based upon a misconception of the enemy's strength. It required that a well-armed, wary and vigilant enemy of unknown strength, some ninety miles away, in a country well known to him but unknown to us, should be approached by two columns, the enemy, as it turned out, exceeding in numbers the two columns combined. Even if Custer had gone quite to the south and had not attacked, the plan put it in the power of the enemy to defeat at least one of the columns as he defeated Crook. Custer, no doubt, thought if he was strong enough to go to the south and wait to be attacked, he was strong enough to make the attack, and Terry's instructions left the matter to his judgment.

Terry stated in his report that he believed his plan might have resulted in a "waiting fight" through which the column first engaging the enemy might hold him until the other came up, the implication being that advantage from a "waiting fight" was lost through Custer's action. The truth is that a "waiting fight" is exactly what was secured, but there was no advantage in it. Custer's command, south of the enemy, kept him engaged from the 25th until the evening of the 26th, when the column from the north approached. Then the Indians quietly slipped away without the northern column being able to detain or injure them.

Godfrey gives the details of Custer's three days' march and of the fight on the 25th and 26th. When the command was nearly in contact with the enemy, Custer directed one company to guard the pack train, sent three companies under Benteen to the south, no doubt in deference to Terry's advice to see that the Indians did not pass that way, ordered Reno with three companies to charge northward down the valley upon the enemy's flank, and with the rest of his force, some 250 men, galloped down the river about three miles to attack in front. The result is known. It is not bad tactics to throw a part of the attacking force upon the exposed flank of the enemy, and support it by a front attack with the other part, and that is what Custer did. To "support" the flanking force is not necessarily to follow it. Custer's "pursuit" to the field where he "caught" the Indians was rapid, but his defeat is not to be attributed to fatigue of horses or men. The offensive is often more fatiguing than the defensive, but the loss of a battle is seldom, if ever, due to the fatigue of the attacking force.

During the Indian outbreak at Pine Ridge Agency, 1890, a battalion of the 9th Cavalry, under Colonel Henry, accompanied by a section of Light Battery E, 1st Artillery, marched as follows: December 24, between 2:30 P. M. and 3:30 next morning fifty miles and six miles further after daylight; scouted actively on the 25th, 26th and 27th, made forty-four miles on the 28th, and starting at 9:30 A. M. on the 29th made ninety-six miles before 4 P. M. on the 30th; was all the time ready for battle, had a skirmish, and marched six miles after the skirmish, making 102 miles in thirty hours.¹

1. Lieutenant A. W. Perry, in the Journal of U. S. Cavalry Association.

The part taken by the companies under Reno proved that Custer's force was not too tired to go into the fight and maintain it until the evening of the 26th. The command was probably no more fatigued than cavalry usually is when it attacks in a vigorous pursuit.

Having marched leisurely from Fort Lincoln on the Missouri to the Rosebud on the Yellowstone, the men and horses were well seasoned but not worn, and Reno has stated that when the regiment moved out on the 22d of June," the men and officers were cheerful," the "*horses were in best condition.*" After Custer "caught" the Indians, their "escape," against which he was warned in Terry's written instructions, could be prevented only by attack. The trouble was their strength was underestimated. Terry reported, July 2: "He (Custer) expressed the utmost confidence he had all the force he could need. *and I shared his confidence.*" Believing, as he and Sheridan and Terry did, that he was strong enough for victory, if Custer had not attacked, and the Indians had moved away, as they did when Gibbon's column approached on the 26th, Custer would have been condemned, perhaps disgraced. With his 600 troopers he could not *herd* the Indians, nor, in that vast, wild, and difficult region, with which they were familiar and of which we were ignorant, could he by going further to his left, "south," drive them

against Gibbon's column. His fight was forced by the situation. Believing, as Custer and his superiors did, that his 600 troopers were opposed by only 500, or at the most 800 warriors, his attack shows neither desperation nor rashness. General Sherman said that when Custer found himself in presence of the Indians he could do nothing but attack.²

In relation to Reno's part, it is proper to state that General Sherman, in his official report, 1876, commends "the brave and prudent conduct of Major Reno," and in 1879 a Court of Inquiry was convened at Reno's request to examine into his conduct in the battle. The court was created by the President and he approved its findings. It reported the facts as it found them, and said "the conduct of the officers throughout was excellent, and while subordinates in some instances did more for the safety of the command by brilliant displays of courage than did Major Reno, there was nothing in his conduct which requires animadversion from this court." Conceding to Reno the right to the benefit of these indorsements, there are some facts which should be noted.

"About the same time that Reno's command was crossing the river in retreat," after it had been engaged only "half an hour or forty-five minutes in all," says the Reno Court of Inquiry, Benteen approached.

His three companies doubled Reno's force, giving him six companies, whereas Custer had only five. Another company with the pack-train arrived a little later. Custer's need of men and ammunition was shown by his last order, which Benteen received before joining Reno. "Come on. Big village. Be quick. Bring pack." Under the circumstances, Reno might well have treated this order as applying to him, as well as to Benteen. As soon as the Indians had driven

2. New York City, May 11, 1891. Dear Fry: In reply to your note, I cannot recall the whole conversation between General Sherman and myself. I remember distinctly that I was much distressed and greatly excited. The conversation took place not long after Custer's defeat. I condemned everything and everybody, and no doubt I spoke only words of passion without judgment. I think I said that Custer's command was in no condition to fight when he made the attack. To this, or something like it, Sherman said when Custer found himself in the presence of the Indians, he could do nothing but attack. Very truly, etc., T. L. Crittenden.

The only son of the gallant Union general who wrote the above note fell upon the field with Custer.

him back they concentrated upon Custer.

"During a long time" after Benteen joined Reno, says Godfrey, Custer's firing was heard, showing that his five companies were hotly engaged with the opposing force, which Reno had found too strong. If Reno had marched then with his six companies to the sound of Custer's carbines, it would have been conduct to commend, and might have enabled Custer to extricate the command. *When it did move out it was too*

late; Custer's men had been killed and the enemy was able to oppose Reno with his whole force and drive him back and invest him in his place of refuge.

Crook's and Terry's columns having been defeated, they were heavily reinforced; and on the 30th day of July a staff officer from Chicago arrived at Terry's camp with orders for Terry and Crook to unite. After their junction—August 10—there was much marching, but no fighting. The enemy could not be "caught."

Child Management*

By DR. D. A. THOM

Good Habits May Be Taught

Tendencies toward thinking and acting in certain ways, which are called habits, are the outgrowth of training and experience. They are not inherited. We begin to form habits at birth and go on through life, forming them quickly and easily in youth and more slowly and with difficulty as the years advance. The oftener the act is repeated or the thought is indulged in the more lasting the habit becomes. Since habit formation begins early and is more or less constant throughout life it is of great importance that emphasis be placed upon establishment of desirable habits.

A young child has certain characteristics that make the acquiring of new habits easy. For one thing, he is suggestible; that is, he accepts without reasoning about it anything which comes from a person he looks up to. "My father said so" or "My mother did it" makes a thing absolutely right for a little child. Again, a child naturally tends to imitate the words, actions, and attitudes of the

people around him, and this makes it of the greatest importance that older people furnish him the kind of models they want to have copied. Furthermore, a child wants to please those he loves and wants to have them say so. At first it is only father or mother or some one in the immediate family whose good opinion he wants. Then it is the kindergarten or school teacher. Finally, at 9 or 10, the praise or blame of his playmates or of the gang leader concerns him more than anything else. When this stage is reached parents should not be disheartened and think that their boy is developing into a black sheep. It is a perfectly natural stage which children pass through and which calls only for greater care in the selection of wholesome companions.

This attitude of concern regarding what other people think is a force that parents may use in developing right conduct. **Rarely is a child found** who does not care for the approval of some one, and training should make a child realize that it is to his advantage to win approbation for desirable acts. Praise for unselfishness, kindness, and general consideration for others tends to perpetuate that type of conduct.

*This article is part of Publication No. 143 of the Children's Bureau of the U. S. Department of Labor, Washington, D. C. The entire bulletin may be secured free by writing to the bureau.

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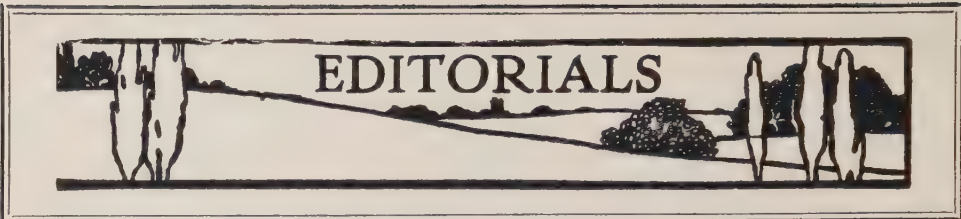
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EDITORIALS

PACIFISM

The Editor having exhausted his vocabulary in the many editorials on the unholy partnership existing between the pacifists and the anarchists is glad to occasionally quote from others and takes pleasure in publishing the following editorial which appeared in "The Chicago Tribune" on Sunday, November 1, 1925, on "We Fashion an Army."

We Fashion an Army

At the University of Illinois, except for a few physically unfit and a few pacifists, they have universal military training. At the University of Wisconsin they don't.

That is agreeable to Illinois. When the next war comes, Illinois will furnish the officers. Wisconsin will furnish the men.

Not pleasant for Wisconsin, not a delectable outlook to stomach. But it is the logical result of too much La Follettism. You can't stuff yourself on pacifist pap and have your Sam Browne belt, too.

The students of Illinois are taking advantage of a form of government insurance that costs them nothing. They get an endowment policy that starts making returns the minute they have made the first payment of a few hours of work and study. They receive health and character in constant dividends that do not cease when the military training comes to an end.

In addition to this personal benefit, they insure themselves, their families, their country—perhaps not against war; that were too sanguine

—but against the fate of being vanquished by an enemy who saw fit to prepare, as America in her wealth and ease never sees fit to prepare.

There are some at Illinois who object to military training. James O'Donnell Bennett made a careful survey of the causes underlying this phenomenon of young Americans enjoying the benefits of a state supported school, but unwilling to defend that state.

There are some who object on moral and religious grounds, object honestly. About these, there is no great cause for concern. There are some of these who say, "I will not fight, even if an enemy invades my home and rapes my sister." Shocking on the face of it. But we agree with Mr. Bennett's quotation of William Winter that these are "juvenile squeaks." There is character there, even if it is of a fanatically distorted sort. Most of them would snap out of it if the catastrophe they seem to contemplate so calmly were threatened.

These religionists, Mr. Bennett learned, are but a "pathetic fringe" about the greater group of malcontents whose reasons are not wholesome, the apex of whose discontent is epitomized in what the students themselves call the "pornographic pacifists."

A little learning, unless there be character behind it, works out to strange ends in young men. It develops strange beings, to be regarded with pity softening the scorn. They

squeak plagiarisms concerning their souls and their thoughts, when they have never passed through the fires that torture souls into being and their thoughts are as standardized as they say are the thoughts of the despised Babbitts whose money furnishes them their little knowledge.

They are a pitiful lot. But we find a place for them, too, in our scheme of national defense.

In our army the officers will come from Illinois, the enlisted men from Wisconsin. And the unconscientious objectors, since they will not fight, shall be the stretcher bearers, whose casualties, as shown by the statistics of the world war, averaged higher than those of any other branch of the service.

A VOICE FROM THE PAST

Among other interesting material by our faithful correspondent, P. J. Stirling Boyd, Esq., whose charming wife, by the way, is the daughter of the late Professor Laycock, one of the brilliant medical men of the University of Edinburgh, we print a letter to Mr. Boyd by Oliver Wendell Holmes written in Boston, March 15, 1874, as follows:

P. J. Stirling Boyd, Esq.,
Edinburgh, Scotland.

My Dear Sir:

I have read your very kind letter with great interest and thank you most cordially for all its expressions of regard for my writings and myself. It is the best reward of authorship to make friends of those who were strangers until our written thoughts had made a home in their intelligence and it may be in their affections. I have had this pleasure not rarely, but I hardly know when I have received any more convincing evidence that I had spoken to the heart of one I never met than I find in your frank and sympathetic letter.

I listen with great respect to the suggestion you make as to my writing out my faith more distinctly than can be gathered in the hints to be found in what I have published. I shall think of what you say, but I cannot promise anything at present. I can adopt your motto "Confido," but when it comes to "Explico" I find the traditions in which I was bred in conflict with the blood I inherit. When the battle is over (which perhaps may never be), I shall be readier to proclaim my credo than I am at this time.

Thanking you once more for all your pleasant words, I am, my dear sir,

Very truly yours,

(Signed) OLIVER WENDELL HOLMES.

HISTORY OF THE CHRISTMAS SEAL

Einar Holboell, a Danish postal clerk, conceived the idea of using penny stickers at Christmas time to help tuberculous children on Christmas Eve, 1903. In his work he saw countless stamps passing through his hands and the idea came to him that seals could be sold to help humanity.

In 1907, through the influence of an article by Jacob Riis in the Outlook Magazine telling of the success of the Christmas seals sold in Denmark, Miss Emily P. Bissell, a Red Cross worker in Wilmington, Delaware, brought the idea to this country. That year through her efforts 300,000 seals were sold to aid the fight against tuberculosis in her district, bringing in \$3,000.

In 1908, the American Red Cross took up the enterprise on a national scale, and in 1910 arrangements were made with the National Tuberculosis Association to manage the seal sale. Each year this organization assumed more responsibility until in 1919 the Red Cross transferred to the Tuberculosis Association the right to use the double barred cross as a symbol of its work, and withdrew from the seal sale. Since that time

the National Tuberculosis Association and its 1,400 local affiliated agencies have carried on the annual sale independently.

This year more than a billion and a quarter seals have been put in circulation in an effort to raise over \$5,000,000 to carry on the national crusade against tuberculosis.

They should no longer be called Red Cross seals but *Christmas seals*.

ABSTRACTS FROM THE BRITISH PRESS

Our esteemed correspondent, Mr. P. J. Stirling Boyd of Edinburgh, sends us the following articles which are of value to us showing what is going on abroad, of interest to us in these cosmopolitan days:

Mysteries of Cancer

Dr. Thomas Lumsden, who, as already stated in *The Daily Mail*, has been granted by the Grand Council of the British Empire Cancer Campaign £1,000 a year for six years to devote his whole time to cancer research, yesterday showed a *Daily Mail* reporter some remarkable results of his efforts to solve the mystery of cancer.

This was in his laboratory at the Lister Institute of Preventive Medicine, Chelsea, London, S. W., where for some time past Dr. Lumsden has been carrying out experiments on rats, mice, and rabbits.

He has succeeded, as others had previously done, in "growing" cancer cells, and under the microscope the latest growths were to be seen. They were like minute jellyfish, and almost perfectly round.

"They are fat and round just at this moment because they have recently been fed," Dr. Lumsden explained. "Normally they are spiky little creatures and variedly shaped.

"I have found," he added, "that cancer cells will grow quite rapidly in normal serum, but that they can be killed within a few minutes by serum obtained from an animal which has been immunized against the particular brand of cancer."

The next thing to try was to produce similar results in the living animal. This also has succeeded, for it is found that in certain

conditions one can kill out malignant tumors in a living rat by means of the anti-serum.

When an animal had two tumors and one of them was killed by injecting anti-serum into it and near it, the remaining untreated tumor gradually disappeared too. This would appear to indicate that the killed or degenerate cancer cells act like a vaccine and bring about an active immunity in the animal.

Encouraging Facts

Killing an inoculated tumor in an animal, however, is a very different thing from dealing with a spontaneous tumor in a human being. At the same time the fact that the former can be done is sufficiently hopeful to encourage further efforts to unravel some of the mysteries of malignant growths.

Dr. Lumsden added that he was now trying to discover whether he could so treat cancer cells taken from a living body that when injected into that body again they would produce immunity from the disease.

"This will be my chief line of inquiry for some time to come," he said. "If I succeed it will remain to be seen whether this method can be applied to cancerous tumors in human beings. While I am hopeful that future experiments will be of definite use in dealing with cancer, it must be understood that, although we who are engaged in cancer research are making progress, we have not yet arrived at a stage where it is possible to do anything for man—and it will, even if all goes well, be some time before we can possibly reach that stage."—*Daily Mail*.

The Voluntary Hospitals

The sixth annual report of the Voluntary Hospitals in Great Britain (excluding London, just issued by the Joint Council of the Order of St. John of Jerusalem and the British Red Cross Society, is of more than usual public interest. A summary of the report, issued from 19, Berkeley Street, W.1, at 1s., is as follows:

Six years' experience has shown that one of the soundest measures of post-war reconstruction was to associate the Order of St. John of Jerusalem and the British Red Cross Society by means of a Joint Council. It has furnished the provincial hospitals with a valuable bureau of information in the interests of popularity, efficiency, and economy, as well as an observation, centre for analyzing and recording the progress made.

The present annual report, as prepared and

signed by Dr. F. N. Kay Menzies, the Council's Director of Hospital Services, is the sixth of the series, and recent events combine to invest it with exceptional importance. Among them may be mentioned the rapid growth of the contributory system among our artisan population, the movement in favor of standardizing Voluntary Hospital accounts, as far as possible, and the issue of the Onslow Commission's report.

The completeness of the present survey is shown by the fact that it covers 95 per cent of the 793 hospitals in the provinces, including 98 per cent of the available beds, and this completeness is all the more remarkable because the rendering of so much information and experience is itself an outcome of the voluntary system.

It is on the strength of all this first-hand experience that the present report formulates certain broad conclusions which may be summarized as follows:

The North's Lead

On a total expenditure of £5,742,706 in 1924 the English and Welsh hospitals showed a balance of £453,143; and on a corresponding expenditure of £1,017,781, the Scottish hospitals showed a balance of £696,142.

This comparison with Scotland is worth emphasizing in more than one respect. For instance, the total of legacies received by hospitals in England and Wales for 1924 was £576,337, or £15 per bed, as against £599,090 in Scotland, or £79 per bed. Again, the comparison of interest from invested funds shows £711,253 in England and Wales, or £19.31 per bed, as against £205,850 in Scotland, or £27.14 per bed.

In England and Wales there are 36,831 available beds, as compared with 7,853 in Scotland, but, at any rate, the support which Scotland gives her hospitals in the form of legacies affords an example well worthy of reflection and imitation.

Special Features

In addition to sections justifying these conclusions, and a series of about sixty statistical tables, many of them supported by graphs printed in color, and all based on wide investigation, the Joint Council's report contains a number of contributions on special aspects of hospital policy and administration, all from eminent experts in their several fields. Thus after reviewing the well-known reasons why

the vocation of nursing makes higher demand than ever on its members, and why its recruiting dwindles, comparatively speaking, owing to competition with other callings more promising and lucrative, Mr. H. N. Crouch, Chairman of the Somerset Voluntary Hospitals Committee, discusses various pension schemes that have been devised to safeguard the future for nurses, and also the bearings of the recent Contributory Pensions Act.

Mr. H. S. Souttar, Chairman of the British Medical Association's Hospitals Committee, surveys the different solutions of the private hospital or "paying" ward problem, which is to extend the same benefits as the rich and poor enjoy to the "great hard-working middle class who form the backbone of our nation."

A Century Ago

Mr. R. H. P. Orde supplies an interesting historical study of provincial hospitals a century ago in all their various aspects. Even the vast improvement that has taken place in hospital construction and equipment in the interval does not dim the national pride with which we may read the following tribute, written just over 100 years ago, merited as it was:

"The erection of infirmaries, by the contribution of individuals and the support of them by private subscriptions, are, with few exceptions, peculiar to the British nation, of which the Christian and patriotic spirit is also displayed in the very general determination that relief to the sick poor shall not be distributed in a niggardly manner. Hence has arisen the observation of foreigners, that in England the poor are accommodated in palaces."

Of like historical interest is Sir D'Arcy Power's account of the State or municipal pawn-offices ("monts de piété"), which, from the Roman era onwards, lent money to the poor, and yielded profits which in various lands went to maintain the hospitals. Among the last of these were certain ill-starred experiments in Ireland, and we get an interesting letter from Sir Charles Barrington concerning one presented to Limerick by his family nearly a century ago.

This collection of specialized knowledge from so many eminent authorities and leaders in hospital progress helps to complete a memorable and valuable survey of that most British of institutions, the Voluntary Hospital, at a critical stage of its career.—*The Times*.



BOOK REVIEWS

MASSAGE AND THERAPEUTIC EXERCISE.

By Mary McMillan, Supervisor of Aids in Physiotherapy, Medical Corps, U. S. A., 1919-20. Second Edition, Reset. 12 mo. of 331 pages with 17 illustrations. Philadelphia and London: W. B. Saunders Company, 1925. Cloth, \$2.50 net.

Mary McMillan, supervisor of Aids in Physiotherapy, Medical Corps, U. S. A., 1919-20, and director of Physiotherapy in courses for graduates of Harvard Medical School, 1921-25, has given us a very excellent book which appeared first four years ago and proved so popular that the second edition has now been called for.

This edition has been completely revised and amplified in regard to therapeutic exercise. Also the treatment of recent fractures has been rewritten, and many new pictures have been added. To those who do not desire a larger book it will answer all their wants being a book of some three hundred pages, well illustrated, and containing about as much as the average physician cares to read, covering practically the same subjects as are covered by larger works, this volume being intended to demonstrate the uses of massage and therapeutic exercise.

THE THERAPY OF PUERPERAL FEVER.

By Privatdozent Dr. Robert Koehler, formerly Assistant of the Gynecological Department of the Krankenhaus Wieden (Director: Hofrat Professor Dr. Josef Halban) in Vienna, Austria. American Edition prepared by Hugo Ehrenfest, M. D., F. A. C. S., Associate in Obstetrics, Washington Uni-

versity School of Medicine, Obstetrician and Gynecologist of The Jewish Hospital, Consulting Obstetrician to St. Louis Maternity Hospital, St. Louis. With twenty-seven illustrations. The C. V. Mosby Co., St. Louis. Price, \$4.00.

This treatise by Dr. Robert Koehler of Vienna, Austria, is most interesting, and we feel grateful to Dr. Ehrenfest in translating it for the use of the profession here. As Dr. Ehrenfest states, no work dealing specifically with puerperal infection has been presented to English speaking physicians within the last fifteen years.

The treatment of systemic infections by means of antiseptic solutions directly infused into the blood, chemotherapy and special non-specific protein therapy are all considered in the volume before us. A large number of cases are reported, and in quite a number of them some excellent results are shown by the intravenous injection of 2 per cent solution of dispergen.

All those interested in the subject of puerperal infection will find much of value in this excellent translation.

THE MEDICAL CLINICS OF NORTH AMERICA. (Issued serially, one number every other month.) Volume IX, Number III, New York Number, November, 1925. Octavo of 312 pages, with 72 illustrations. Per clinic year (July, 1925, to May, 1926). Paper, \$12.00; Cloth, \$16.00 net. Philadelphia and London: W. B. Saunders Company.

This is the New York number and has contributions by a number of active clin-

icians in New York, among them H. O. Mosenthal, Howard F. Shattuck, Seymour Fiske, Walter A. Bastedo, Joseph M. Marquis, and others. Among the interesting clinics we note renal glycosuria, digitalis dosage, quinidin, bulimia, syphilis of the stomach, cardio spasm as well as a number of other interesting subjects.

A TEXTBOOK OF PHYSIOLOGY. By William D. Zoethout, Ph. D., Professor of Physiology in the Chicago College of Dental Surgery (Loyola University) and in the Chicago Normal School of Physical Education. Second edition. The C. V. Mosby Co., St. Louis. Price, \$4.50.

This book is a happy medium between the exhaustive works on physiology and the compendiums. It is a book of some six hundred pages. This is the second edition of this valuable book and has in every way been brought up to date.

For dental students, especially, as well as students of pharmacy and students of normal schools we consider this book meets all and every need, and while medical students possibly require a larger work this book fills all the usual wants of the students in the classes indicated.

PHYSIOTHERAPY THEORY AND CLINICAL APPLICATION. By Harry Eaton Stewart, M. D., President-elect American Academy of Physiotherapy; Attending Specialist in Physiotherapy, U. S. Marine Hospitals, N. Y.; Director New Haven School of Physiotherapy; formerly Assistant Director, Section of Physiotherapy, Office of the Surgeon General, U. S. Army, and Supervisor of Physiotherapy, Bureau of U. S. Public Health Service, Washington.

The talented author who has written much on physical reconstruction, orthopedics, diathermy, etc., has given us a

most practical book on the subject of physiotherapy or physical therapeutics. In part one, the author covers galvanism, electrolysis, faradism, static, frequency currents, phototherapy, hydrotherapy, thermotherapy, actinotherapy, massage, exercise, etc.

Part two, deals with the clinical application of physiotherapy in the various diseases of the neuro-muscular system, cardio-vascular system, genito-urinary system, respiratory system and cardio-vascular system, diseases of the bones and joints, skin, etc.

The book is splendidly illustrated, right up to date, and is such a practical type of a book that we earnestly recommend our readers to get familiar with the benefits now obtained by physiotherapy by carefully studying this valuable book.

WILLIAM CADOGAN (His Essay on Gout).

By John Ruhrah, M. D., Professor of Diseases of Children, University of Maryland. Paul B. Hoeber, Inc., New York. Price, \$1.50.

This interesting essay on gout by William Cadogan, who lived 1711-1797, is most interesting throughout, and no one can help but enjoy his dissertation. In Cadogan's opinion gout was caused by indolence, intemperance, and vexation, and he gives many good arguments to prove that these are the original causes of gout as well as other chronic diseases.

His treatment is practically the treatment of today and really covered by Cadogan's cure consisting of activity, temperance, and peace of mind.

We advise all our readers to have a real rare treat by getting a copy of this most interesting and inexpensive book.

A TEXTBOOK OF MEDICAL DIAGNOSIS.

By James M. Anders, M. D., Professor of Medicine, Medico-Chirurgical College, Graduate School of Medi-

cine, University of Pennsylvania, and L. Napoleon Boston, M. D., Associate Professor of Medicine, Graduate School of Medicine, University of Pennsylvania. Third Edition, Entirely Reset. Octavo of 1422 pages, 555 illustrations, some in colors. Philadelphia and London: W. B. Saunders Company, 1925. Cloth \$12.00 net.

This one volume book on medical diagnosis by professor J. M. Anders, whose name is a household word wherever medicine is known, and L. Napoleon Boston, associate professor in the Graduate School of Medicine, University of Pennsylvania, appears now in the third edition. We know that Anders' means perfection, and we cannot add anything new to what we said when the second edition appeared.

In a volume of this size, over fourteen hundred pages, it is, of course, impossible to say much more than to call attention to a few of the changes in the third edition. It has been brought completely up to date and represents a most exhaustive discussion of all the diagnostic aspects of medical diseases. The author states that on account of the limitation of space the descriptive cases of former editions have been omitted, and many technical details have been simplified. The valuable diagnostic tables, we are glad to say, have been retained in this edition. Of the very long list of subjects which have been enlarged in this volume, we can only mention a few such as spinal tumors, the thyroid and thymus gland, the pituitary gland, the pineal gland, the gonads, eosinophilic leukemia, pyorrhea and focal infection, radiation sickness, basal metabolism, botulism, trench fever and a very large number of other topics. In short, this volume remains, as before, one of the three best works on medical diagnosis published in the English language.

APPLIED BIOCHEMISTRY. By Withrow Morse, Ph. D., Professor of Physiological Chemistry and Toxicology, Jefferson Medical College, Philadelphia. Octavo of 958 pages with 257 illustrations. Philadelphia and London: W. B. Saunders Company, 1925. Cloth, \$7.00 net.

Even a cursory glance of this splendid work convinces one that it is written by a master mind and that it will at once take rank with the foremost works published on this subject. Every detail is covered in this book of over nine hundred pages treating of man and his environment, chemical action, energy producers, the glucids, the proteids, chemistry of the tissues and common foods, digestion and absorption of foods, nutrition from the chemical standpoint as well as the energetics of nutrition, metabolic adjuvants, metabolic studies on blood, etc. In short, anyone desiring an authoritative work on applied biochemistry, written by a master of this science should get a copy of this excellent work.

AMERICAN BOARD OF OTOLARYNGOLOGY

An examination was held by the American Board of Otolaryngology on October 19, 1925, at the Cook County Hospital, Chicago, with the following result:

Passed	120
Failed	23
Total Examined	143

The next examination will be held in Dallas, Texas, on April 19, 1926. Applications may be secured from the Secretary, Dr. H. W. Loeb, 1402 South Grand Boulevard, St. Louis, Mo.

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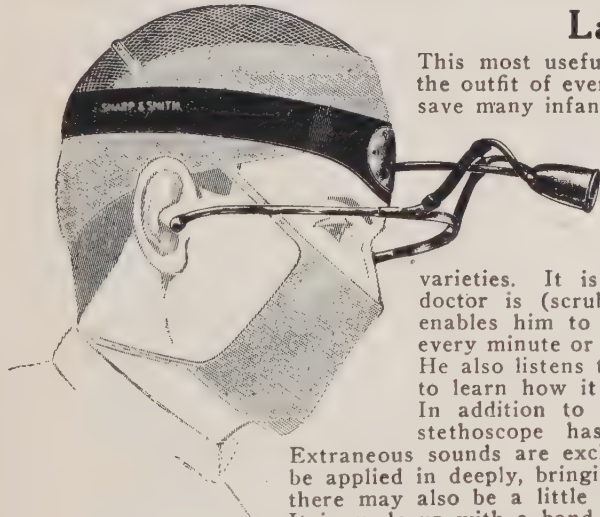
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KEEPING UP WITH THE DOCTORS

By James J. Montague

(N. Y. Herald-Tribune, April 14, 1924.)

Said the doctor: "Your troubles are due to your teeth;

That is why you feel listless and mean;"

And he gazed at my molars above and beneath,
With the aid of an X-ray machine.

"Yes! Yes!" he observed, when the survey was done,

"That's the matter with you, beyond doubt."

So I went to a dentist—he told me of one—
Who savagely pulled them all out.

But still I was racked by all manner of pain,
Though I hadn't a tooth in my head;
As the time dragged along it grew daily more plain

That I'd soon be confined to my bed.
So another physician I hastened to see,
Who drew a small tube from its sheath,
Found my temperature up to a hundred and three
And said, "It's because you've no teeth."

The teeth were extracted and wouldn't grow back,
So I suffered and groaned for a while,
And the future looked dreadfully dreary and black,

Till they altered the medical style.
For all of the doctors this year are agreed
That there's nothing in dosing and pills,
And in all their professional journals I read
That teeth are the cause of all ills.

I am feeling much better, but how can I tell
That soon some distinguished physician
May not say I have never a chance to get well,
Because of my toothless condition?
I am inwardly trembling with shuddery fear,
Though I'm outwardly stoic and brave,
For if teeth are declared to be vital next year,
There is nothing ahead but the grave!

A Canine Vegetable.—"Yes," the teacher explained, "quite a number of plants and flowers have the prefix 'dog.' For instance, the dog-rose and dog-violet are well known. Can any of you name another?"

There was silence, then a happy look illuminated the face of a boy at the back of the class. "Please, miss," he called out, proud of his knowledge, "colli-flower!"—The Progressive Grocer.

May the Survivor Recover!—
TWO TRUCKS CRASH,
ONE DEAD, ONE HURT.
—Philadelphia Public Ledger.

The Height of Candor.—Mrs. A.—"I make it a rule never to ask another to do what I would not do myself."

Mrs. B.—"But, my dear, surely you don't go to the door yourself and tell your caller you are not at home."—Boston Transcript.

She Had Him Down Pat.—The fresh young traveling salesman put on his most seductive smile as the pretty waitress glided up to his table in the hotel dining-room to get his order, and remarked:

"Nice day, little one."

"Yes, it is," she replied. "And so was yesterday, and my name is Ella, and I know I'm a pretty girl and have lovely blue eyes, and I've been here quite a while, and I like the place, and don't think I'm too nice a girl to be working here. My wages are satisfactory and I don't think there's a show or dance in town tonight, and if there was I wouldn't go with you, I'm from the country and I'm a respectable girl, and my brother is the cook in this hotel, and he was a college football player and weighs three hundred pounds; last week he pretty nearly ruined a \$25-a-week traveling man who tried to make a date with me; now, what'll you have—roast beef, roast pork, Irish stew, hamburger or fried liver?"—Everybody's Magazine.

Wages in Florida.—2 BOAT carpenters on new towboat, \$100 per hour. F. Howard, 1719 N. W. 1st St.—Miami Herald.

Missed His Chance.—Lady—"Why aren't you a successful business man?"

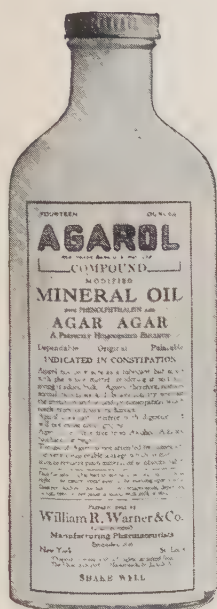
Tramp—"You see, lady, I wasted me time in school instead of selling newspapers."—Life.

Another Faithful Reader.—"Why, my dear man, already my poetry is being read by twice as many people as before."

"Oh—I didn't know you had married."—Brisbane (Australia) Mail.

Oh, Don't Mention It!—Mrs. Smith (after ten minutes' conversation)—"Well, Mrs. Brown, I must be getting along to the plumber. My husband's home with his thumb on a burst pipe, waiting till he comes."—Good Hardware.

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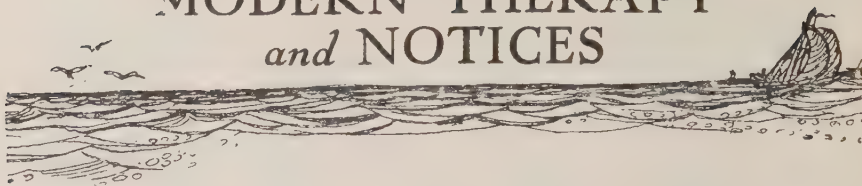
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MODERN THERAPY and NOTICES



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While these blocks have not been generally placed on sale, samples are available to physicians who are interested, and any physician who will write to H. K. Mulford Company, P. O. Box 1404, Philadelphia, mentioning this Journal, will receive a full size package for clinical test, free of all charge.

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This form of urethral irritation (simple urethritis) is often manifest in patients with gout, or in an attack of grippe, and during an acute exacerbation of the disease, diabetic patients are similarly annoyed. Alcoholic excesses, arsenic, iodide of potash and other remedies used in general practice will at times light up a urethral irritation. To remedy this condition, no happier selection could be made than SANMETTO. This scientific and well-balanced preparation may be administered to man, woman or child without fear of causing gastric trouble. And in this instance again it is necessary to assure oneself that the genuine SANMETTO is dispensed, as

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Phytolaccin	1/2 gr.		

Prescribe: Rx—One to two capsules three or four times daily.

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More Men Suicides Than Women

New York.—"Suicide, in the wage-earning group of American and Canadian populations, is approximately two and one-half times as frequent among men as among women," says the Statistical Bulletin of the Metropolitan Life Insurance Company, based on a study of 16,000,000 industrial policyholders.

The ratio, it is stated, relates to all ages combined, but the proportion varies according to age. Between 15 and 20 suicide is more common among girls, but between 20 and 24, the men show the greater death rate, about one and a half times as many men as women. Between 55 and 64, there are about five times as many men, and after 65 about seven times as many.

Solid and liquid poisons are preferred by women up to 45 years, and after that gas inhalation; while among the males shooting is most generally used. It is also stated that among men there is a marked relation between the suicide rate and business conditions, the greater number of deaths occurring after a dull period, but that among women there is no such relation.

Two Deaths From Administration of Barium Salts.—In a review of the literature from 1910, twelve deaths from barium carbonate, six deaths from barium chlorid and four deaths from barium sulphid poisoning were found by W. D. McNally, Chicago (*Journal A. M. A.*, June 13, 1925). He adds two cases of barium sulphid and barium carbonate deaths. Barium poisoning manifests itself by great weakness, salivation and nausea. Vomiting and diarrhea follow, the purging is very violent, and causes severe abdominal pains. At this stage, usually, the victim becomes very cold. There is a catarrhal affection of the conjunctiva, the mucous membrane of the respiratory tract and the nose. Paralysis of the extremities and finally of the trunk are succeeding developments. The muscles of speech become very weak early in the poisoning, and swallowing very difficult. Consciousness always remains to the end. Treatment usually consists of ingestion of magnesium or sodium sulphate, stomach lavage, hot bags around the abdomen and spine, stimulation with aromatic spirit of ammonia, and strychnin injection. McNally urges that the barium sulphate given to patients for roentgen-ray examination should be only a chemically pure grade and be given by the person who is to make the examination. Each lot of barium sulphate should be tested for soluble barium compounds. In this way faulty prescriptions of physicians and careless dispensing by pharmacists would be avoided.

Amount of Whisky Under Government Control.—There are 20,000,000 gallons of preprohibition whisky now in storage in the United States, under government supervision; and its owners—mostly wholesale dealers who had whisky on hand when national enforcement became effective—cannot legally dispose of it except as the government directs. Under plans

put into effect by Prohibition Commissioner Roy A. Haynes, the present supply of whisky is concentrated in twenty-eight warehouses, located largely in Kentucky. This stock is being consumed on medical prescriptions at the rate of about 1,750,000 gallons annually, according to Director Haynes, and will be sufficient to last only seven years. About 1928, four years before the present whisky stock is exhausted, it is expected that the government will authorize the manufacture of whisky so that 4-year-old spirits may be available as medicine when the preprohibition supply shall have been exhausted.

CHOLECYSTITIS AND CHOLELITHIASIS IN YOUNG CHILDREN

Three cases of gallbladder disease in children under 10 years of age are reported by C. C. Snyder, Pasadena, Calif. (*Journal A. M. A.*, July 4, 1925). The children were aged 4, 5½ and 9½ years, respectively. The patients were operated on, and in each case drainage was followed by uneventful recovery. The preoperative diagnosis in these three cases was acute appendicitis.

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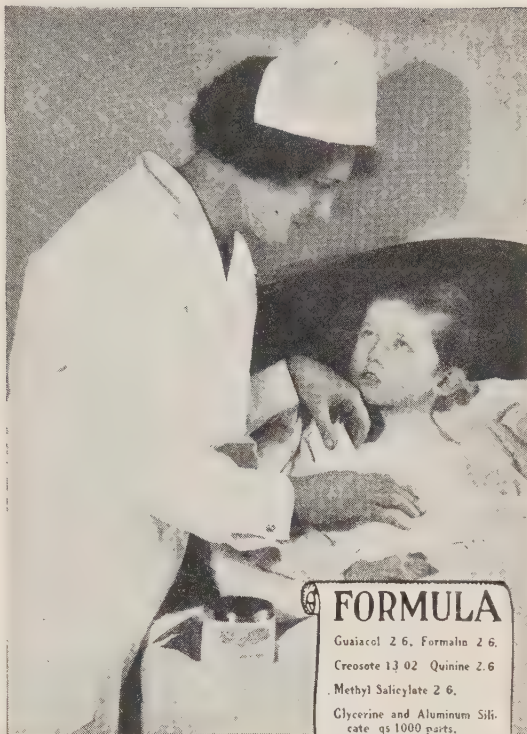
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Effect of Germanium Dioxid on the Rabbit.—G. H. Bailey, P. B. Davidson, Boston, and C. H. Bunting, Madison, Wis. (Journal A. M. A., June 6, 1925), have not found germanium dioxid to be a hematopoietic stimulus in the rabbit. On the other hand, although a rabbit may survive a large dose of the drug (more than 200 mg. intraperitoneally), yet, in doses as small as 4 mg., the drug is toxic for the man parenchymatous organs, resulting either in the death of cells, or in an eventual atrophy following a state of hydropic degeneration with increased autolysis.

Echinococcus Cyst of the Kidney.—David R. Melen, Rochester, N. Y. (Journal A. M. A., June 6, 1925), reports one case and reviews the literature briefly. Of the seventeen cases occurring in this country, a correct diagnosis was made before operation in only four, by the history of the patient voiding small cysts. Of the remaining cases, in six the diagnosis was tumor of the kidney, the true nature of which was revealed at operation. In two, the enlargement of the kidney was discovered by palpation during a laparotomy for some abdominal condition and later verified by a kidney operation. In five cases the diagnosis was established at necropsy, no operation having been performed.

The Female Sex Hormone and Gestational Gland.—Robert T. Frank and R. G. Gustavson, Denver (Journal A. M. A., June 6, 1925), summarize their most important conclusions thus: Each sex cycle is preparatory to gestation, the normal sex cycle being the fertile one that leads uninterruptedly to parturition and lactation. An abortive cycle occurs when pregnancy fails to develop. Soon after ovulation the anabolic phase ceases, a catabolic period succeeding it. In most forms the catabolic period is involuntary. In the primates this period is destructive (menstruation). The endocrine factors producing the cyclic changes are successively supplied by the follicle, corpus luteum and placenta. To emphasize this continuity, the authors propose the name of the gestational gland for this triad (follicle, corpus luteum and placenta). By substitution (subcutaneous injection) with lipid extracts of these glands (follicle fluid, corpus luteum, placenta) they have obtained: In female castrates or in immature animals alike: (a) premature sex development

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(pubertas praecox); (b) hyperplasia of the tubular system, and mammae, especially marked in rabbits. In castrates: (c) in rats, vaginal spreads characteristic of estrus, together with hyperplasia of the duct system; (b) in rats, treated with potent extracts, typical estrual contractions of the uterus suspended in Locke's fluid. The active substance has been sufficiently concentrated to produce physiologic results in a total dosage of 2.25 mg. (0.00225 gm.). The sex hormone is a specific substance elaborated by the gestational gland, taken up by the lymph and blood stream and selectively utilized only by Müller's tract and the mammary glands. The chemistry of the sex hormone is not fully determined.

JOURNAL OF BIOLOGICAL CHEMISTRY BALTIMORE

62: 1-286 (Nov.) 1924

Effect of Ultraviolet Light on Calcium and Phosphorus Equilibrium.—Hart, Steenbock and Elvehjem present data showing that ultraviolet light can influence the storage of calcium and phosphorus and the equilibrium of these elements in the blood stream of mature animals in a way similar to its effects on growing animals. Two mature, lactating goats and a mature, dry goat were brought into distinctly negative calcium balances, or calcium equilibrium, on a ration deficient in the antirachitic factor; on exposure for twenty minutes daily to the emanations from a quartz mercury vapor lamp, negative calcium balances were changed to distinctly positive balances. The inorganic phosphorus of the blood was also appreciably increased through radiation. On similar calcium and phosphorus levels of intake and in the presence of low amounts of the anti-rachitic factor, mammary secretion brings on rapidly a negative calcium balance as compared to a nonlactating animal.

BOSTON MEDICAL AND SURGICAL JOURNAL

191: 1057-1100 (Dec. 4) 1924

Classification of Juvenile Tuberculosis.—Chadwick urges the adoption of the term hilum tuberculosis which describes the disease in the children whose tuberculosis is as yet confined to the lymphoid tissue about the trachea, the right and left bronchus and the larger subdivisions of the bronchi. It is in this tissue that tubercle bacilli lodge and very frequently produce disease in children from 3 to 12 years of age. Later, if the disease is not arrested in these glands, the parenchymatous tissue becomes involved and then the adult type of pulmonary tuberculosis develops. This can then be classified under the accepted nomenclature of minimal, moderately advanced, or advanced—according to the stage of the disease. Hilum tuberculosis is a comparatively benign condition when contrasted with pulmonary disease even when it is in an early stage of development. The prognosis of hilum tuberculosis is good when treatment is given. From an economic point of view a child with hilum tuberculosis when restored to health and a state of normal nutrition by being taught good habits and good hygiene is a good insurance risk.



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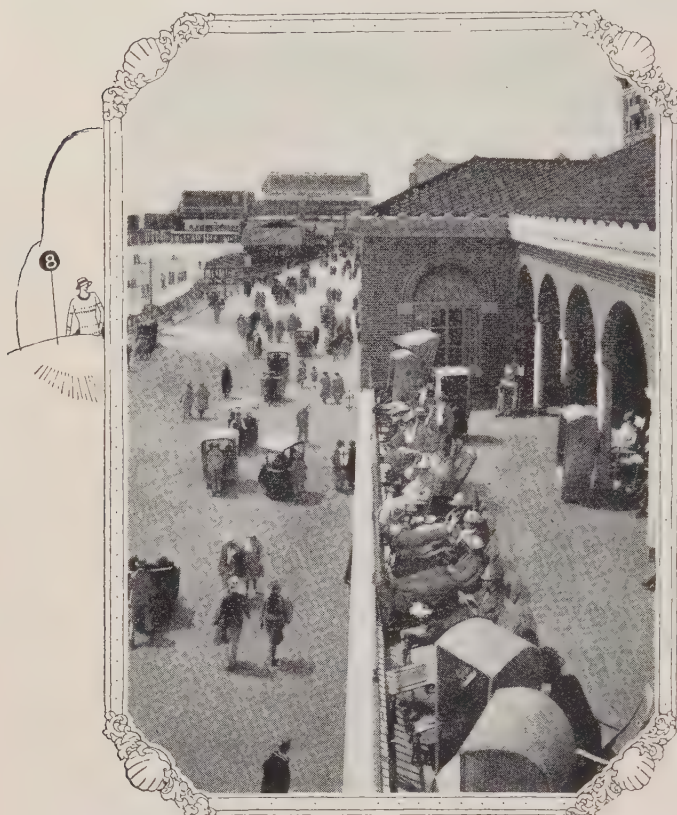
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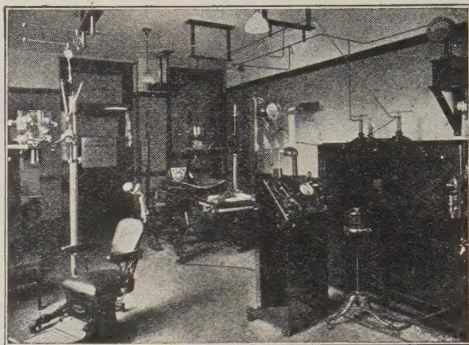
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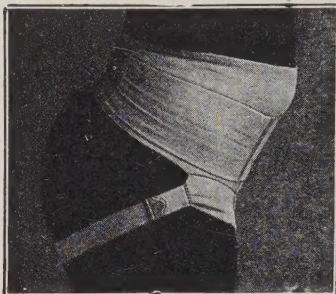
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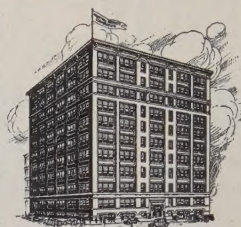
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